Vermont Department of Health - Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT
LIMITED TEMPORARY PHYSICIAN
APPLICATION CHECKLIST

Application for License to Practice Medicine in Vermont

- Please print legibly or type.
- Answer all questions completely.
- Make a copy of the completed form and all attachments for your records.
- Please be sure to write your name on each attachment.
- Do not delegate this important task to any other person. False statements on this form may be grounds for unprofessional conduct.

Please submit the following as part of your application.

- ☐ A check in the amount of $50 payable to the Vermont Department of Health
- ☐ Applicant's statement regarding Child Support, Taxes, and Unemployment Compensation Contributions whether or not you have children
- ☐ Copy of medical school diploma
- ☐ **Direct verification**-The "CERTIFICATE OF MEDICAL EDUCATION" form must be completed by the school of medicine and returned directly to the board.
- ☐ **Direct verification-**The "CERTIFICATE OF MEDICAL LICENSURE" form must be completed by the Medical Board of each state where a license is or has been held (temporary or full).
- ☐ Copy of ECFMG certificate
- ☐ Form A to provide explanations to "yes" answers in Parts II-IV

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. Box 70, Burlington, VT 05402

LIMITED TEMPORARY PHYSICIAN LICENSE APPLICATION

I hereby make application for a Limited Temporary License to practice medicine and surgery as an intern resident, fellow or medical officer in the State of Vermont at the _____ Hospital or Institution, Department of _____, under the supervision of _____, MD and submit the following information.

Part I

1. Name: _____
(Last) (First) (Middle) (Extension)

a. Have you ever legally changed your name? ___Yes ___ No
If yes, enter your former name, or other name under which you were licensed in Vermont or elsewhere in the past two years;_____

b. Your name, as it should appear on your license: _____

2. Date of Birth: _____
(Month) (Day) (Year)

3. Home Address:

_____
(Street)

_____
(City) (State) (Zip)

4. Work Address:

_____
(Street)

_____
(City) (State) (Zip)

5. Please check your preferred mailing address: ____ Home ____ Work
NOTE: ***The mailing address will be listed on the Board's web site.***

6. Home Telephone Number: (_____) _____

7. Work Telephone Number: (_____) _____

8. E-mail address: _____

Part II

9. Are you currently participating in residency or fellowship training? □ yes □ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state? □ yes □ no
If yes, complete the section below:

State	License Number	Type of License	Date Issued	Status (Active or Inactive)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

11. Have you ever applied for and been denied a license to practice medicine or any other healing art?
□ yes □ no

12. Have you ever withdrawn an application for a license to practice medicine or any other healing art?

□ yes □ no

13. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?

□ yes □ no

14. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

□ yes □ no

15. Have you ever been denied the privilege of taking an examination before any state medical examining board?

□ yes □ no

16. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family need?

□ yes □ no

17. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

□ yes □ no

18. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes □ no

19. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes □ no

20. Are you presently a defendant in a criminal proceeding?

□ yes □ no

Part III
Confidential Section (The following section is exempt from public disclosure)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

21. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?
□ yes □ no

22. To your knowledge, are you presently the subject of criminal investigation?

□ yes □ no

The following definitions are provided to assist you in answering the following questions. Please explain any "**Yes**" answers on Form A.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

23. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

24. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

25. Are you currently engaged in the illegal use of controlled substances?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part IV

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best you can. You will receive a copy of your profile each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive copies of court papers, licensing and certification authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

26. **Criminal Convictions** [See 26 VSA § 1368(a)(1)]

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

□ Not applicable

(Conviction Date)	(Court)	(City/State)	(Crime
(Conviction Date)	(Court)	(City/State)	(Crime)

27. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)]

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide copies of papers fully documenting these matters.**

□ Not applicable

(Conviction Date)	(Court)	(City/State)	(Charge)
(Conviction Date)	(Court)	(City/State)	(Charge)

28. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

□ Not applicable

(Date)	(Final Disposition - Summary)

29. **Licensing or Certification Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide copies of papers fully documenting these matters.**
□ Not applicable

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

30. **Restriction of Hospital Privileges** [See 26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions**

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide copies of papers fully documenting these matters.**
□ Not applicable

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. **Other Restrictions**

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide copies of papers fully documenting these matters.**
□ Not applicable

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) □ In lieu □ In settlement

31. **Medical Malpractice Court Judgments/Settlements** [See 26 VSA § 1368(a)(6A)]

A. **Judgments**

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**
□ Not applicable

□ Judgement □ Arbitration

(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)

□ Judgement □ Arbitration

(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)

B. Settlements

Please provide a description of all settlements of medical malpractice claims against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**
□ Not applicable

(Date)	(Court)	(State)	(Amount of Settlement Against You)

(Date)	(Court)	(State)	(Amount of Settlement Against You)

32. **Medical Professional Schools** [See 26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.) Please attach a copy of diploma.

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation/Anticipated Year of Graduation)

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation/Anticipated Year of Graduation)

If necessary, please use an additional sheet and check this box: .....□

33. **Graduate Medical Education** [See 26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education that you have received or will receive. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)	(Anticipated Training)

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)	(Anticipated Training)

If necessary, please use an additional sheet and check this box: .....□

34. **Specialty Board Certification** [See 26 VSA § 1368(a)(9)]

Enter up to three specialty codes from the enclosed ***Specialty Codes List***. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			
		☐ yes ☐ no			

35. **Years of Practice** [See 26 VSA § 1368(a)(10)]

What month and year did you start practicing as a physician (including residency)?

_____

36. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges. ☐ Not applicable

_____

(Name) (City) (State) (Year Started)

_____

(Name) (City) (State) (Year Started)

37. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] ☐ Not applicable

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

_____

(School) (City) (State) (Nature of Appointment) From (year) To (year)

_____

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

_____

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

38. **Publications** [See 26 VSA § 1368(a)(13)] ☐ Not applicable

Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years. ☐ Not applicable

_____

(Title) (Publication) (Year)

(Title) (Publication) (Year)

39. **Activities** [See 26 VSA § 1368(a)(14)] . □ Not applicable

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards

(Activities or Awards)

40. **Practice Setting** [See 26 VSA § 1368(a)(15)]

What is the location of your primary practice setting? □ Not applicable

Town or City State

41. **Translating Services** [See 26 VSA § 1368(a)(16)]

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? □ Not applicable

If yes, please describe here the translating services available:

If necessary, please use an additional sheet and check this box: .....□

42. **Medicaid/New Patients** [See 26 VSA § 1368(a)(17)]

A. **Medicaid participation**
Do you participate in the Medicaid program? □ yes □ no □ not applicable

B. **New Medicaid Patients**
Are you currently accepting new Medicaid patients? □ yes □ no □ not applicable

Part V

Photograph
PLEASE PROVIDE A PHOTOGRAPH:
Attach a recent photograph (head and shoulders). Proofs are not acceptable.
Please sign the front of the photograph.
Do not use staples.

PHOTOGRAPH

Part VI

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

I hereby aver that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date:_____ _____

Applicant's Signature

Vermont Department of Health
Board of Medical Practice
P.O. Box 70, Burlington, VT 05402

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

Withdrawal or denial of License (Questions 11 and 12) - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

Voluntarily surrendered or resigned a license to practice medicine or any healing art (Question 13) - Attach documents

State_____ Year_____

Circumstances_____

_____

Disciplinary charges or action (Question 14) - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)_____

Circumstances_____

_____

_____

Denial of examination privileges (Question 15) - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

Residency Training Program(s) not completed - discontinued education, training, practice (Questions 16 and 17) - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

Affecting Health Care Institution Staff Privileges, Employment or Appointment (Question 18) - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

Privilege to prescribe controlled substances (Question 19) - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

Criminal Investigation - Proceeding (Questions 20 and 22) - Attach documents

Court _____

City and State _____

Charge _____

Description _____

Status _____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

Investigation by any other licensing board (Question 21) - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

Medical condition, treatment, use of chemical or illegal substances (Questions 23-25)

Treating organization _____

Address _____Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

Vermont Department of Health - Board of Medical Practice
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:

- ❑ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

- ❑ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes."Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below regarding taxes:

- ❑ I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

- ❑ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

- ❑ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a $10, 000.00 fine or both.)

or

- ❑ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

- ❑ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* _____/_____/_____ Date of Birth _____/_____/

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant_____ Date_____

SPECIALTY CODES LIST

(primary care specialties in boldface)

0101 Allergy and Immunology
0102 Clinical & Laboratory Immunology

0201 Anesthesiology
0202 Critical Care Medicine
0203 Pain Management

0301 Colon & Rectal Surgery

0401 Dermatology
0402 Dermatopathology
0403 Clinical & Laboratory Dermatology
0404 Dermatological Immunology

0501 Emergency Medicine
0502 Medical Toxicology
0503 Pediatric Emergency Medicine
0504 Sports Medicine

0601 Family Practice
0602 Geriatric Medicine
0603 Sports Medicine

0701 Internal Medicine
0702 Adolescent Medicine
0703 Cardiac Electrophysiology
0704 Cardiovascular Disease
0705 Critical Care Medicine
0706 Clinical & Lab Immunology
0707 Endocrinology Diabetes & Metabolism
0708 Gastroenterology
0709 Geriatric Medicine
0710 Hematology
0711 Infectious Disease
0712 Medical Oncology
0713 Nephrology
0714 Pulmonary Disease
0715 Rheumatology
0716 Sports Medicine

0801 Medical Genetics
0802 Clinical Biochemical Genetics
0803 Clinical Biochemical/Molecular Genetics
0804 Clinical Cytogenetics
0805 Clinical Genetics (Md)
0806 Clinical Molecular Genetics

0901 Neurological Surgery
0902 Critical Care Medicine
1001 Nuclear Medicine

1101 Obstetrics & Gynecology
1102 Critical Care Medicine
1103 Gynecologic Oncology
1104 Maternal & Fetal Medicine
1105 Reproductive Endocrinology

1201 Ophthalmology

1301 Orthopaedic Surgery
1302 Hand Surgery

1401 Otolaryngology
1402 Otology/Neurotology
1403 Pediatric Otolaryngology
1501 Anatomic & Clinical Pathology
1502 Anatomic Pathology
1503 Clinical Pathology
1504 Blood Banking/Transfusion Medicine
1505 Chemical Pathology
1506 Cytopathology
1507 Dermatopathology
1508 Forensic Pathology
1509 Hematology
1510 Immunopathology
1511 Medical Microbiology
1512 Neuropathology
1513 Pediatric Pathology

1601 Pediatrics
1602 Adolescent Medicine
1603 Clinical & Laboratory Immunology
1604 Medical Toxicology
1605 Neonatal-Perinatal Medicine
1606 Pediatric Cardiology
1607 Pediatric Critical Care Medicine
1608 Pediatric Emergency Medicine
1609 Pediatric Endocrinology
1610 Pediatric Gastroenterology
1611 Pediatric Hematology-Oncology
1612 Pediatric Infectious Disease
1613 Pediatric Nephrology
1614 Pediatric Pulmonology
1615 Pediatric Rheumatology
1616 Pediatric Sports Medicine
1617 Children with Special Health Needs

1701 Physical Medicine & Rehabilitation

1801 Plastic Surgery
1802 Hand Surgery

1901 Preventive Medicine
1902 Aerospace Medicine
1903 Occupational Medicine
1904 Public Health & General Preventive
1905 Medical Toxicology
1906 Underseas Medicine

Psychiatry & Neurology
(Board Name - Not A Specialty)
2001 Psychiatry
2002 Neurology
2003 Neurology With Special Qualifications In Child Neurology
2004 Addiction Psychiatry
2005 Child & Adolescent Psychiatry
2006 Forensic Psychiatry
2007 Geriatric Psychiatry
2008 Clinical Neurophysiology

2101 Radiology
2102 Diagnostic Radiology
2103 Radiation Oncology
2104 Radiological Physics
2105 Nuclear Radiology
2106 Pediatric Radiology
2107 Vascular & Interventional Radiology
2201 Surgery
2202 Surgery Of The Hand
2203 Pediatric Surgery
2204 Surgical Critical Care
2205 General Vascular Surgery
2301 Thoracic Surgery

2401 Urology

4001 Abdominal Surgery
4002 Acupuncture
4003 Addiction Medicine
4004 Adult Reconstructive Orthopedics
4005 Allergy

4006 Cardiovascular Surgery
4007 Clinical Pharmacology
4008 Diabetes

4009 Facial Plastic Surgery

4010 General Practice

4011 Gynecology
4012 Head & Neck Surgery
4013 Hepatology
4014 Homeopathic Medicine
4015 Immunology

4016 Legal Medicine
4017 Musculoskeletal Oncology
4018 Neuroradiology
4019 Nutrition
4020 Obstetrics

4021 Oral & Maxillofacial Surgery
4022 Orthopedic Surgery Of The Spine
4023 Orthopedic Trauma
4024 Pain Medicine
4025 Pediatric Allergy

4026 Pediatric Ophthalmology
4027 Pediatric Orthopedics
4028 Pediatric Surgery (Neurology)
4029 Pediatric Urology
4030 Psychoanalysis

4031 Radioisotopic Pathology
4032 Sports Medicine (Orthopedic Surgery)
4033 Traumatic Surgery
4034 Sleep Medicine

9001 Rotating Internship (Residency)
9999 Other - Please Specify

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

APPLICATION FOR LIMITED TEMPORARY LICENSE

CERTIFICATE OF MEDICAL EDUCATION

To be completed by an ***officer of your school of medicine***

I hereby certify that _____ was admitted to the
(Name)

_____ School of Medicine in

_____ on _____
and
(City/State)

completed all requirements for graduation on _____.
(Date)

A _____ was granted/will be granted on
(Specify Certificate/Diploma/Degree)
_____.
(Date)

Date: _____

Signed: _____ [Affix Seal]

Printed Name: _____

Title: _____

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

APPLICATION FOR LIMITED TEMPORARY LICENSE

CERTIFICATE OF MEDICAL LICENSURE

This section must be completed by the regulatory authority in the states in which you now hold or have ever held a license to practice medicine, including a limited temporary and/or training license.

I, _____, Secretary of the _____ State board of medical examiners, certify that _____ was granted Certificate Number _____ to practice medicine in the State of _____ on the _____ day of _____, _____, and that said certificate has never been revoked, suspended or conditioned in any way, or the licensee has never been disciplined by the board in any way.

NOTE: If licensed by written examination, the secretary should further certify:

I further certify that the aforesaid _____ in his/her written examination before this board, obtained a general average of _____ percent in the following branches:

(The subjects of the examination and rating of each must be stated in full.)

_____

_____

_____

Date: _____

Signed: _____ [Affix Seal]

Printed Name:_____

Title: _____

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF PROGRAM DIRECTOR/SUPERVISING PHYSICIAN

This section must be completed by the Program Director/physician who will be supervising your work in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetence of the licensed physician or upon ten days written notice of the licensed physician.

I certify that (name of applicant) _____ is under my direct supervision and control **in a formal ACGME-approved residency program** at:

Hospital or Institution:

_____

Department:

_____

Address:

_____

City, State, Zip Code

_____

For the period _____ to _____.

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

_____ _____

Signature of Program Director/Supervising Physician | Program Director/Supervising Physician's Vermont License Number

_____ _____

Printed Name of Program Director/Supervising Physician | Date

_____

Address

_____

City, State, Zip Code

PLEASE MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF THE PROGRAM DIRECTOR

This section must be completed by the Director of the residency program in which the applicant is currently engaged.

I certify that (name of applicant) _____ is engaged as an intern, resident, fellow or medical officer at:

Hospital or Institution:

_____

Department:

_____

Address:

_____

City, State, Zip Code

_____

For the period _____ to _____.

I further state that (name of applicant) _____ is a resident/fellow in good standing and is scheduled to participate in an ***away rotation*** at:

Hospital or Institution:

_____

Department:

_____

Address:

_____

City, State, Zip Code

_____

For a period of _____ to _____. This is an approved rotation within the framework of the residency program.

_____ _____

Signature of Program Director Date

_____

Printed Name of Program Director

PLEASE MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.